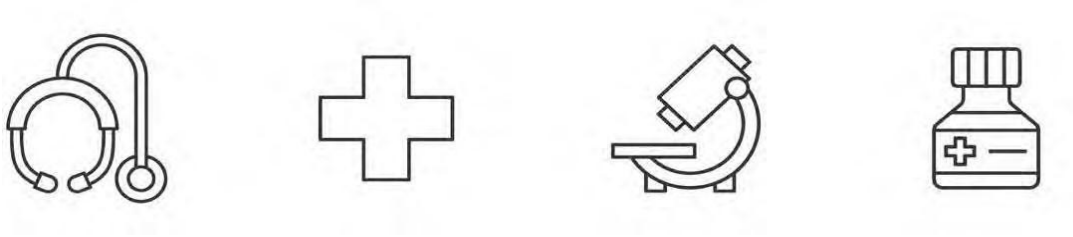
Arizona Department of Administration

ADOA Benefit Options
2022 Benefit Guide
Retired Employees



ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

benefitoptions.az.gov

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Purpose of This Guide

This guide describes the comprehensive benefits package “Benefit Options” offered by the State of Arizona, Department of Administration HR - Benefits effective January 1, 2022. This reference guide includes explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts.

This guide is intended to help you understand your benefits, covering specific benefits programs or essential information. We encourage you to review all your options before making your benefit elections. Additional information specific to active, retiree, or COBRA enrollees is available in specially marked sections.

The actual benefits available to you and the descriptions of these benefits are governed in all cases by the Section 125, relevant plan descriptions, and insurance contracts. The State of Arizona reserves the right to modify, change, revise, amend, or terminate these benefits plans at any time.

For more detailed information, please refer to your plan descriptions. If you need additional information, please visit our website at benefitoptions.az.gov or call us at 602-542-5008 or toll-free at 1-800-304-3687.

Benefit Changes for Plan Year 2022

The 2022 Benefits Plan Year is January 1 - December 31, 2022. For a full explanation, please see the pages noted.

Premiums - Your premiums for all plans will stay the same for 2022.

Plans - All plans will remain the same for 2022, including medical, prescription drug, dental, vision, short-term disability, life insurance and wellness programs. There are no changes to copays, deductibles, or out-of-pocket maximums.

Carriers - The carriers for all plans will remain the same for 2022.

Eligibility

Retirees

The following persons are eligible to participate in the Benefit Options Plan:

A. Retirees with a pension from a State-sponsored retirement Plan and continuing enrollment in the retiree health and/or dental Plan.
B. Long-Term Disability (LTD) participants collecting benefits under a State-sponsored Plan.
C. Eligible former elected officials and their eligible dependents if the elected official has at least five years of credited service in the Elected Officials Retirement Plan (EORP); was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.
D. Surviving spouse and eligible dependents of a retiree covered at the time of the retiree's death.
E. Surviving spouse of a former elected official covered at the time of the official's death.
F. Surviving spouse and eligible dependents of a deceased law enforcement officer killed in the line of duty whether they were covered or uncovered at the time of death.
G. Surviving spouse and eligible dependents of an active member who is eligible to retire who is covered at the time of the employee's death.

Eligibility Rules

As an eligible retiree, if you elected ADOA's medical or dental insurance, you may make changes to your plan(s) during Open Enrollment or changes consistent with a Qualified Life Event (QLE).

If you have declined or canceled medical and/or dental coverage in the past, but have maintained either coverage through ADOA, you may re-elect medical and/or dental coverage during an Open Enrollment period.

Dependents

The following dependents may be added to your plans:

A. Your legal spouse
B. Your child defined as:
    a. A natural child, adopted child, stepchild, foster child, a child for whom there is court-ordered guardianship or a child with a court order pending adoption who is younger than age 26.
    b. Your child who is disabled and continues to be disabled as defined by 42 U.S.C. 1382c before the age of 26.

If you have a qualified dependent that is not currently enrolled in the Benefit Options Plan, he or she may be added during an Open Enrollment period. Dependents not enrolled during Open Enrollment cannot be added until the next Open Enrollment unless there is a QLE. You have 31 days from the date of the QLE to change your enrollment through ADOA HR - Benefits. The change must be consistent with the event. Please refer to the Benefit Services website, benefitoptions.az.gov, for more information about QLEs.

Qualified Medical Child Support Order (QMCSO)

You may not terminate coverage for a dependent child covered by a QMCSO.

Dependent Support Document Requirements

Proper documentation is required after enrollment of a dependent:

- You are enrolling a dependent, the dependent's coverage will not be processed until supporting documentation such as a marriage license for a spouse, or a birth certificate or court order for a dependent, is provided to the ADOA HR - Benefits.
- Your dependent child is approaching age 26 and has a disability. Application for continuation of dependent status must be made within 31 days of the child's 26th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, which occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.

Please refer to the Summary Plan Document for a complete list of eligible and ineligible dependents and eligibility requirements. You can also see a list of documents listed on the "Qualified Life Event and Mid-Year Changes Chart" on benefitoptions.az.gov/QLEchart.

Social Security Numbers - Members are required to provide Social Security Numbers (SSN) for all dependents enrolled in the Benefit Options medical plans. This requirement is in accordance with the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) which was effective January 1, 2009.

Qualified Life Events

You may only change your benefit elections when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next open enrollment period to make benefit changes. Events that may be considered include but are not limited to:

- Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse.
- Changes in dependent status: birth, adoption, placement for adoption, guardianship, death, or dependent eligibility due to age.
- Changes in employment status or work schedule that affect benefits eligibility for you, your spouse, and/or dependents.

Submitting a Change Request

Requested benefit changes must be submitted in writing to the ADOA HR - Benefits within 31 calendar days of the event.

Effective Date of the Change

The effective date of coverage beginning or ending depends on the type of event following the date the requested change and required documentation is submitted to ADOA HR - Benefits. For more information on documentation, refer to the "Qualified Life Event and Mid-Year Changes Chart" on benefitoptions.az.gov/QLEchart.

The effective date for benefit changes based on all other QLEs is the first day of the next calendar month, following the date the retiree submits the requested change, along with required documentation, in writing, to ADOA HR - Benefits.

Effective the 1st day of the month after completing the enrollment process	Effective the date of birth, adoption or court order	Effective the date of the event
• Marriage • Divorce, annulment or legal separation • Employment status change	• Newborn • Adopted Child • Guardianship	• Death of dependent • Return from Military Leave

Please consult with ADOA HR - Benefits to determine whether or not the life event you are experiencing qualifies under the regulations. Any change in premiums due to a QLE will be in effect the first of the month following the receipt of all QLE documentation.

New Retiree's Option of Life Insurance Continuation

As a new retiring State of Arizona employee, you have the option of continuing all or a portion of your Life Insurance coverage with Securian. There are two options for continuation of coverage:

- Converting your group Life coverage to your own individual policy.
- Porting your Life coverage which continues as a term life policy. To be eligible for portability, you must terminate employment prior to the Social Security Normal Retirement Age.

To apply for Conversion or Portability, you must apply within 31 days of the termination of your Life Insurance or within 15 days of the date you receive the COBRA notification. For questions or to apply, call Securian at 833-745-5517.

Dual Coverage

If you and your spouse are both State employees and/or retirees, dual coverage of an employee, spouse and dependent, is not permitted under this Plan. An employee may elect coverage for their entire family, including the State employee spouse, or each State employee spouse may elect their own coverage.

You cannot enroll as a single subscriber and be enrolled as a dependent on your spouse's policy simultaneously. If an individual is enrolled in this manner, the dual coverage will be terminated and no refunds will be made for the premiums paid.

End-Stage Renal Disease

If you are eligible to enroll in Medicare as an active employee or retiree because of End-Stage Renal Disease, the Plan will pay for the first 30 months, whether or not you are enrolled in Medicare and have a Medicare card. At the end of the 30 months, Medicare becomes the primary payer. If a plan member who is eligible for Medicare Part B does not enroll in Medicare Part B, the plan will only pay secondary benefits after 30 months of primary coverage. You will also be responsible for Part B covered charges.

Eligibility Audit

ADOA HR - Benefits may audit a member's documentation to determine whether an enrolled dependent is eligible according to the plan requirements. This audit may occur either randomly or in response to uncertainty concerning dependent eligibility. Should you have questions after receiving a request to provide proof of dependent eligibility, please contact the Audit Services Unit within the ADOA HR - Benefits.

Subrogation

Subrogation is the right of an insurer to recover all amounts paid out on your behalf as the insured member. In the event you, as a Benefit Options member, suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and Benefit Options pays benefits as a result of that injury or illness, Benefit Options has the legal right to recover against the party responsible for your illness or injury or from any settlement or court judgment you may receive, up to the amount of benefits paid out by Benefit Options.

As a Benefit Options member, you are required to cooperate with the vendors acting on behalf of ADOA during the subrogation process. Failure to do so may result in legal action by the State to recover funds received by you.

Return to Work Retirees

Former retired State employees returning to active State employment can receive health benefits through the Benefit Options Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in Active benefits and decline retiree benefits. Leaving State employment is considered a QLE. The QLE then allows members to enroll in retiree benefits again.

Continuing Eligibility through COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you experience a loss of coverage due to termination of employment or a qualifying event, you and/or your dependents may extend coverage under the Benefit Options Plan for a limited period of time.

The following individuals would be considered qualified beneficiaries eligible for COBRA coverage:

1. An employee who had coverage through Benefit Options and lost the coverage because of a reduction in hours of employment or a termination of employment for a reason other than gross misconduct.
2. An employee's legal spouse, as defined by Arizona Statute, who had coverage through Benefit Options and lost the coverage for any of the following reasons:
    a. Death of the employee;
    b. Termination of the employee's employment for a reason other than gross misconduct;
    c. Reduction in the employee's hours of employment resulting in a loss of eligibility for coverage;
    d. Divorce or legal separation from the employee;
    e. The employee becomes eligible for Medicare.
3. An employee's dependent child who had coverage through Benefit Options and lost the coverage for any of the following reasons:
    a. Death of the employee (parent);
    b. Termination of the parent's employment for a reason other than gross misconduct;
    c. A reduction in the parent's hours of employment resulting in a loss of eligibility for coverage;
    d. The parents' death, divorce or legal separation;
    e. The parent becomes eligible for Medicare or;
    f. The dependent ceases to be a dependent child as defined by the Benefit Options program.

Age 65

- If you are over 65 and were actively employed, upon leaving State service, you are eligible to elect COBRA coverage. If you are on Medicare when you enroll in COBRA, you may continue coverage.
- If you turn 65 while you are on COBRA coverage, your COBRA medical coverage will be terminated automatically at the end of the month you turn 65 and you then must enroll in Medicare.
    - Dependents:
        - As a dependent, if you turn 65 while you are on COBRA coverage, your COBRA medical coverage will be terminated automatically at the end of the month you turn 65 and you then must enroll in Medicare.
        - If you are not 65, the employee (subscriber) turning 65 is considered a Qualified Life Event (QLE) that allows you to continue with medical coverage on your own under COBRA. You will be required to submit a new COBRA form. You will be assigned a new Participant ID number and you will be responsible for making premium payments.
- Dental and vision coverage may be continued for you and covered dependents.

ADOA HR Division-Benefits will determine final eligibility for COBRA coverage. ADOA HR - Benefits will determine whether the life event you are experiencing qualifies under the Section 125 regulations. Please see p. 49 for more information regarding COBRA coverage.

Summary of Monthly Premiums

Medical

Without Medicare		With Medicare	
Retiree Only	$708.53	Retiree Only	$528.11
Retiree + One	$1,657.21	Retiree + One (both Medicare)	$1049.05
Retiree + Family	$2,233.12	Retiree + One (one Medicare)	$1,223.49
		Retiree + Family	$1,393.16

Dental

	Cigna Dental Care Access	Delta Dental PPO Plus Premier
Retiree Only	$8.52	$35.94
Retiree + Adult	$17.04	$75.63
Retiree + Child	$16.59	$60.48
Retiree + Family	$25.54	$118.26

Vision

	Advantage Program
Retiree Only	$3.99
Retiree + Adult	$12.94
Retiree + Child	$12.76
Retiree + Family	$16.10

Understanding Your Insurance Costs

Calculating your monthly costs, premium benefit, and pension check can be simple. Each retiree's circumstances are different, but understanding how all the pieces work together will make it an easy process. First, premium benefit for the basic program varies depending on your years of service with the State of Arizona, the retirement system you are enrolled in, and the insurance plan in which you enroll. Second, ADOA, ASRS, and PSPRS offer retiree health insurance plans. Premiums differ depending on the plan option selected and whether you are enrolled in single or family coverage.

The worksheet below will help you determine the amount of insurance premiums that will be deducted from your monthly pension. In the event your pension does not cover the net premium, you will be identified as a direct pay member and will be required to pay ADOA.

Net Monthly Health Insurance Cost Worksheet		
Your Monthly Medical Plan Premium (see p. 11)	A	
	+	
Your Monthly Dental Plan Premium (see p. 11)	B	
	=	
Total Premium (A + B = C)	C	
	–	
Your Basic Premium Benefit Subsidy (see p. 14)	D	
	=	
Your Net Premium (C – D = E)	E	

What You Should Know About Premium Payments

You are responsible to pay all premiums. Failure to keep your premiums current will result in the cancellation of your insurance coverage. If the sum of your premium benefit subsidy and pension is greater than or equal to the total monthly premium, you will be considered a non-direct pay member. Non-direct pay members do not receive a bill.

- If you are an LTD member or Surviving Spouse not receiving a pension from a recognized state retirement plan, you are a direct pay member. You are responsible for the payment of your premium(s) by the first of each month. The monthly premium is stated on your enrollment form. The ADOA HR Division-Benefits will mail a bill to you.

- If your monthly pension has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. You will then become a direct pay member. The ADOA HR Division-Benefits will mail a bill to you. It will be your responsibility to pay any outstanding premiums to Benefit Services. If you do not receive a bill by the twenty-fifth day of the month, you must contact Benefit Services.

- Should the retirement system begin deducting your premium from your pension and you have also received a bill as a direct pay member, please contact ADOA HR Division-Benefits. Please see the section entitled, “Information for Direct Pay Members.”

New Retirees/LTD Members

Depending on when the Retirement System receives your benefit elections, you may owe one or more months of health and/or dental premiums. After enrolling, check your pension deductions. If, by your second pension, the deduction has not occurred or the deduction is incorrect, immediately contact ADOA HR Division-Benefits, at 602-542-5008.

Information for Direct Pay Members

If you are or become a direct pay member, you will receive a billing notice regarding future premium payments. If you do not receive a billing notice within 60 days, please call the ADOA HR Division-Benefits at 602-542-5008. Failure to remit premium payments will result in the cancellation of your benefits and may affect your eligibility in the Benefit Options program.

Vision Premium Payments

If you elect vision coverage, premiums are NOT subsidized by your retirement system and are NOT deducted from your pension. You will be billed quarterly premiums directly from Avesis. Avesis will bill you directly for premiums quarterly, refer to pg. 44 for the 2022 Invoice and Payment Schedule. Payments are due within 30 days. Failure to submit your premium payment to Avesis will result in the cancellation of your vision coverage. There will be no refunds for dropped coverage.

Calculating your Premium Benefit Subsidy

Your retirement system will determine if you are eligible for a premium benefit and the amount to which you may be entitled.

The Arizona State Retirement System (ASRS), the Public Safety Personnel Retirement System (PSPRS), the Elected Officials Retirement Plan (EORP) and the Corrections Officer Retirement Plan (CORP) may provide payment toward insurance premiums for eligible members and dependents who elect health coverage through the ADOA HR Division-Benefits. The chart on the next page reflects the maximum monthly premium benefit available for eligible members and their qualified dependents.

No basic premium benefit is provided to Retirees in the University Optional Retirement Plan or to PSPRS or CORP members who are LTD members.

- Your retirement system will determine if you are eligible for a premium benefit and the amount to which you may be entitled. To determine your basic premium benefit, you need to know:
- Your years of credited service in your retirement system or plan if you are an ASRS or EORP member (years of service is not a criterion for CORP and PSPRS members).
- Your coverage type (i.e., single or family coverage).
- Medicare eligibility.

Basic Premium Benefit Subsidy Amounts

	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
Years of Service	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependents One with Medicare, the other(s) without	Retiree & Dependent with Medicare, other dependents without
Arizona State Retirement System (ASRS) Members						
5.0 - 5.9	$75.00	$130.00	$50.00	$85.00	$107.50	$107.50
6.0 - 6.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
7.0 - 7.9	$105.00	$182.00	$70.00	$119.00	$150.50	$150.50
8.0 - 8.9	$120.00	$208.00	$80.00	$136.00	$172.00	$172.00
9.0 - 9.9	$135.00	$234.00	$90.00	$153.00	$193.50	$193.50
10.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0 - 5.9	$90.00	$156.00	$60.00	$102.00	$129.00	$129.00
6.0 - 6.9	$112.00	$195.00	$75.00	$127.50	$161.25	$161.25
7.0 - 7.9	$135.00	$234.00	$90.00	$153.00	$193.50	$215.00
8.0+	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Corrections Officer Retirement Plan (CORP) Members						
Not applicable	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00
Public Safety Personnel Retirement System (PSPRS) Members						
Not applicable	$150.00	$260.00	$100.00	$170.00	$215.00	$215.00

Your Direct Deposit Summary

Pension payments are issued by ASRS or PSPRS. Before either of the retirement systems generates your pension, they apply your premium subsidy (refer to the worksheet on pg. 12). Once the premium subsidy is added into your pension, the retirement system pays for your dental premium first. ASRS or PSPRS will apply the remaining money to pay for your medical premium.

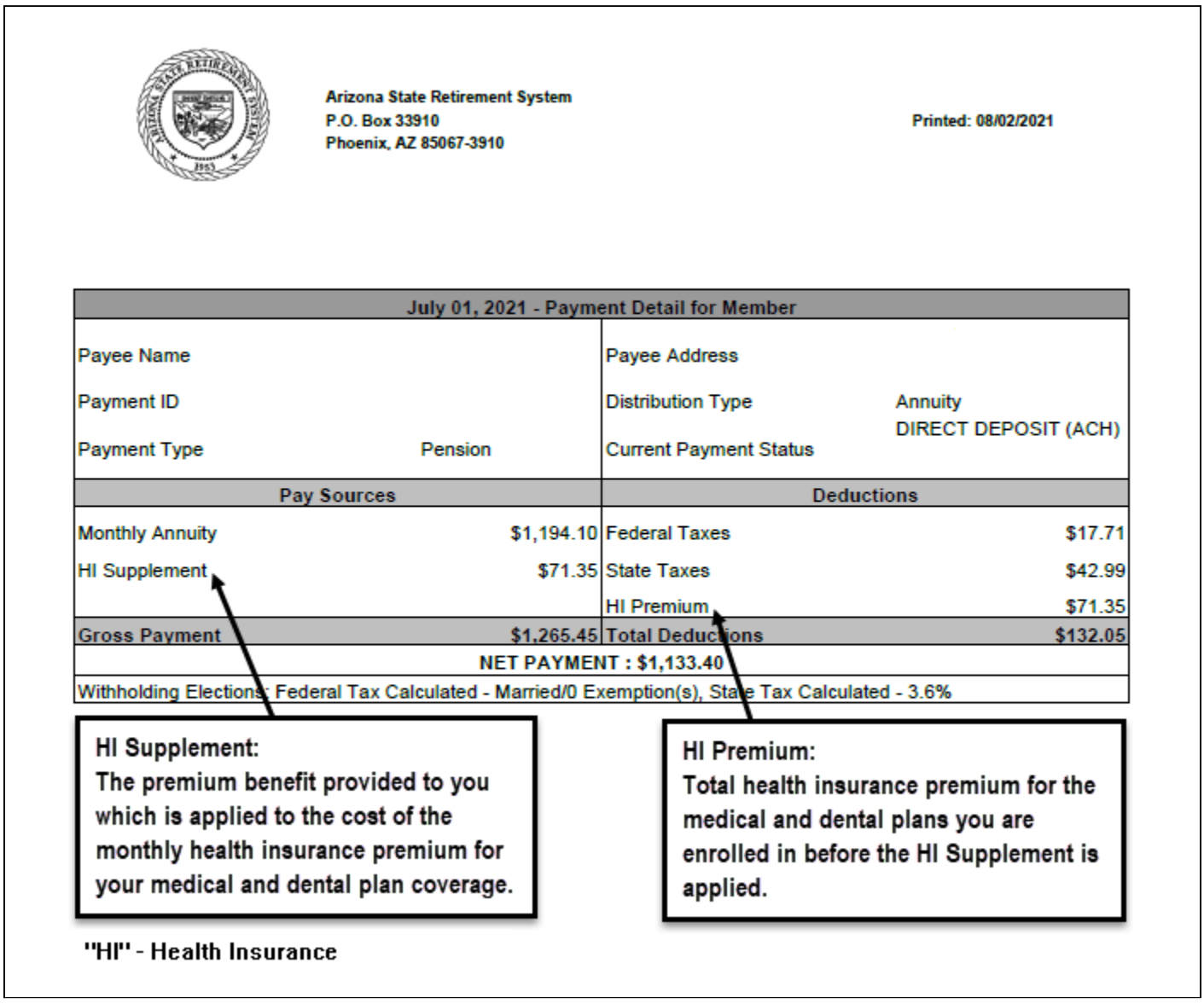
- If your pension is large enough to cover the cost of both your dental and medical premiums, you will receive any remaining money.
- If your pension is not enough to pay for the full cost of your dental and medical premiums you will become a direct pay member.

Please refer to the "Payments" column of the pension Direct Deposit Summary.

An example of an ASRS Direct Deposit Summary is shown on the next page. Please note, under the Payment Sources column, the inclusion of additional monies reflected in the premium benefit (HI PREM BENEFIT). This amount is the premium benefit to which you may be entitled and it reduces the full monthly medical and/or dental premiums you pay.

Also note, under the deductions column, the full health insurance premium for your medical and/or dental coverage (HI Premium). Though the total premium for health insurance is shown, you are only paying the net premium after the premium benefit is applied.

Sample Billing Statement



Arizona State Retirement System
P.O. Box 33910
Phoenix, AZ 85067-3910

Printed: 08/02/2021

July 01, 2021 - Payment Detail for Member			
Payee Name		Payee Address	
Payment ID		Distribution Type	Annuity DIRECT DEPOSIT (ACH)
Payment Type	Pension	Current Payment Status	
Pay Sources		**Deductions**	
Monthly Annuity	$1,194.10	Federal Taxes	$17.71
HI Supplement	$71.35	State Taxes	$42.99
		HI Premium	$71.35
Gross Payment	$1,265.45	Total Deductions	$132.05
NET PAYMENT : $1,133.40			
Withholding Elections: Federal Tax Calculated - Married/0 Exemption(s), State Tax Calculated - 3.6%			

HI Supplement:
The premium benefit provided to you which is applied to the cost of the monthly health insurance premium for your medical and dental plan coverage.

HI Premium:
Total health insurance premium for the medical and dental plans you are enrolled in before the HI Supplement is applied.

"HI" - Health Insurance

Parts of Medicare

Eligibility

Medicare is health insurance available to people who are:

- Age 65 or over.
- Under age 65 with disabilities (receiving LTD from a State-sponsored LTD plan or SSI).
- Diagnosed with End-Stage Renal Disease.

Medicare eligibility is determined by the Social Security Administration. Many people automatically receive Part A and Part B. If you receive benefits from Social Security, you will receive Part A and Part B starting the first day of the month you turn 65. If you are under the age of 65 and disabled, you automatically receive Parts A and B after you receive disability benefits from Social Security. You should receive your Medicare card in the mail three months before your 65th birthday or your 25th month of disability.

Eligibility Notification

If you become eligible to receive Medicare due to a disability, receive your Medicare Card prior to your 65th birthday, or there is a change in your Medicare status, you must contact the ADOA HR Division-Benefits with this information. When you receive your new Medicare card, you must provide a copy of it to Benefit Services. Medicare does not communicate directly with the ADOA HR Division-Benefits.

Parts of Medicare

The different parts of Medicare help you cover specific health services. Medicare has the following parts:

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home healthcare

Medicare Part B (Medical Insurance)

- Helps cover doctors' services and outpatient care
- Helps cover some preventive services to help maintain your health

Medicare Part C (Medicare Advantage Plans)

- A health coverage choice run by private companies approved by Medicare
- Includes Part A, Part B, and usually other coverage including prescription drugs

Medicare Part D (Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

If you choose a doctor that does not accept assignment from Medicare, your doctor may be allowed to bill you for additional costs up to the Medicare limiting charge.

If you enroll in either Medicare Part C or Part D plans other than VibrantRx, you will not be eligible for Benefit Options Medical Coverage. (Example: if you enroll in the Humana Part D Plan outside of the Benefit Options program, you are not eligible to enroll in any of the ADOA Medical Plans.)

Medicare Payments

You will not typically have a monthly premium for Part A if you or your spouse paid Medicare taxes while working. You must pay the standard Medicare Part B premium.

Benefit Options does not pay for Medicare Part B premiums. If you decline or disenroll from Medicare Part B, you will be financially responsible for ALL Part B premiums.

Medicare and ADOA

If you have Medicare Parts A & B during open enrollment, you may elect either the EPO or PPO plan offered at the “with Medicare” premium.

Medicare Primary

If you are retired and receiving a pension from a recognized State-sponsored Retirement Plan, OR you are receiving LTD benefits from a State-sponsored disability plan (Broadspire, Sedgwick, The Standard, Cigna, The Hartford, or MetLife):

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

Medicare Parts A and B will only pay 80% of covered charges once you have met your deductible. Doctors often charge patients the remaining portion of the bill that Medicare has not paid. If you enroll in the Benefit Options plan, the remaining portion (20%), less copays, will be covered since Benefit Options becomes the secondary payor. Benefit Options will pay up to the total allowable amount less copays as determined by the Plan.

If you are enrolled in Medicare Part A only, you are still Medicare-eligible. If you decline Part B, you will be responsible for Part B covered charges.

Payment for Parts A & B

To help you calculate your monthly benefit cost, use the worksheet on pg. 12. If you feel your pension is not accurate, you must notify your Retirement System (ASRS or PSPRS) as soon as possible. If your enrollment is not processed until after the third of the month, it is possible the correct premiums will not be deducted from your pension until the month following the effective date of your enrollment or change.

Copays

A copay is a portion paid by the member to share in the cost of medical services, supplies and prescriptions. Cost sharing helps Benefit Options with healthcare costs. Medicare also applies cost sharing. For covered services, the Benefit Options plans absorb the Medicare deductible you would otherwise pay for hospital and medical services. The Benefit Options program will pay up to the total allowable amount as determined by the Plan. Most physicians charge 20% above the amount covered by Medicare. Copays are required for all plan members regardless of Medicare eligibility or disability. Your medical provider understands medical payments will be reduced by the copay. Therefore, the copay must be made at the time the services are rendered.

Medicare Crossover Program

Medicare Crossover is a process by which Medicare automatically forwards medical claims to your health plan after they have paid as the primary payor. All medical vendors have a Medicare Crossover program. Please call the number on the back of your card and let them know you would like to enroll in the Medicare Crossover program.

Medicare Part D

The Medicare Modernization Act (MMA) established a voluntary prescription drug benefit known as Medicare Part D. This benefit is offered to all Medicare-eligible Retirees or LTD members enrolled in Medicare Parts A and/or B.

All ADOA's Medicare Prescription Drug Plan (PDP) Plan Medicare-eligible participants covered under the State of Arizona Benefit Options Program must enroll in the Medicare PDP that combines a standard Medicare Part D plan with additional prescription drug coverage provided by Benefit Options. The plan name is VibrantRx (Employer PDP). We refer to this program as VibrantRx for Benefit Options.

Low-Income Subsidy (LIS)

Medicare-eligible retirees and their Medicare-eligible dependents with limited income may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare may pay for up to 100% of drug costs, and coinsurance/copayments.

Eligible members are identified during the enrollment process. Plan participants that are eligible will receive a Low-Income Subsidy (LIS) Rider with their Explanation of Coverage explaining their benefit.

For more information about Extra Help, members may contact their local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048, or visit medicare.gov.

Part D Income Related Monthly Adjustment Amount (IRMAA)

If a member's income is greater than $85,001 for an individual (or married individuals filing separately) or greater than $170,001 for married couples, Medicare requires that you pay an additional premium based on your income. You will be notified by Social Security if this affects you.

For more information about Part D premiums based on income, visit medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Members may also call Social Security at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778.

The VibrantRx for Benefit Options plan provides equal to or better coverage than what is offered through Medicare Part D. Learn more about VibrantRx for Benefit Options on pg. 34.

Medical Plan

Understanding Your Options

Retirees have one statewide and nationwide plan and may choose from two Networks. “Network”, describes the company contracted with the State to provide access to a group of providers (doctors, hospitals, etc.). Certain providers may belong to one Network but not another. Plans are loosely defined as the structure of your insurance policy: the premium, deductibles, copays, and out-of-Network coverage.

Triple Choice Plan

The Triple Choice Plan is based on three tiers. For a single premium, you have access to all three tiers as shown below. You’ll save the most when you choose providers from Tier 1, a network of doctors and facilities that meet strict criteria for both quality and cost of care.

- Carriers – Blue Cross Blue Shield of Arizona and UnitedHealthcare.
- **One Plan – The TCP is a single plan, you do not sign up for a specific tier.**
- One Premium – You pay a single premium to access any tier.
- Tier Access – You can access all three tiers of providers and facilities. You control costs by choosing providers and facilities in the lowest tiers. See p. 22
- No Referrals – You can still see the providers you know and trust—even if they aren’t in Tier 1.
- Deductibles – The deductible for Tier 1 counts toward Tier 2 and vice versa. See how deductibles work on p. 9 and the deductible amounts and how they work on p. 22

Tiers		
Tier 1	**In-Network Providers**	Choose doctors & facilities from Tier 1 to get the highest level of benefits.
Tier 2	**In-Network Providers**	You receive in-Network benefits for using participating network care providers. For some services, you’ll pay a higher out-of-pocket cost with a Tier 2 provider than you would with a Tier 1 provider.
Tier 3	**Out-of-Network Providers**	You will pay the highest cost for using out-of-Network providers, and may be responsible for paying the full provider-billed charges.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a doctor who is not contracted with one of the Networks, you can apply for transition of care. TOC forms are available on the Benefit Options website benefitoptions.az.gov.

If you are approved, you will receive in-Network benefits for your current doctor during a transitional period after January 1, 2022. Transition of care is typically approved if one of the following applies:

1. You have a life-threatening disease or condition;
2. You have been receiving care and a continued course of treatment is medically necessary;
3. You are in the third trimester of pregnancy; or
4. You are in the second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan's policies, procedures, and quality assurance requirements.

ID Cards

ID cards are provided only to members who are newly enrolled or make a change to their benefit plan. Personal insurance cards arrive 7-14 business days after the benefit becomes effective.

A new card or replacement ID card can be obtained by contacting the appropriate vendor to request a card, print card via the vendor website, or by downloading the vendor app on your mobile device.

Medical Plan Comparison Charts

Triple Choice Plan - Premiums Per Month[1]			
Without Medicare		**With Medicare**	
Retiree Only	**$708.53**	**Retiree Only**	**$528.11**
Retiree + One	**$1,657.21**	**Retiree + One (both Medicare)**	**$1049.05**
Retiree + Family	**$2,233.12**	**Retiree + One (one Medicare)**	**$1,223.49**
		Retiree + Family	**$1,393.16**

CARRIERS

Coverage		Tier 1	Tier 2	Tier 3
Deductible	**Retiree Only**	$200	$1,000	$5,000
	Retiree + One Retiree + Family	$400	$2,000	$10,000
Out-of-Pocket Maximum[3,4]	**Retiree Only**	$7,350 **Tier 1 & Tier 2 Combined**		$8,700
	Retiree + One Retiree + Family	$14,700 **Tier 1 & Tier 2 Combined**		$17,400
Lifetime Maximum		Unlimited		Unlimited
Routine Preventive Services		$0	$0	$0
Office Visits (incl. Mental & Behavioral Health)				
Primary Care Physician (PCP)		$20	$20	50%
Specialist[5]		$40	$40	50%
OB/GYN		$20	$20	50%
Telemedicine Services		$20	$20	50%
Durable Medical Equipment		$0	$0	50%
Emergency Services[6]				
Ambulance		$0	$0	$0
Emergency Room		$200[6]	$200[6]	$200[6]
Urgent Care		$75	$75	50%
Inpatient Hospital Admission		$250	$250	50%
Outpatient Facility		$100	$100	50%
Laboratory and X-Ray Services[7]		$0	$0	50%
Major Radiology Services[8]		$100	$100	50%

1 For the NAU-only BCBS PPO Plan information, visit nau.edu/human-resources/benefits/benefit-plan-document/
2 Copayments apply after the Plan deductible is met. Copayments and deductibles apply to the Out-of-Pocket Maximum.
3 The Plan pays 100% after the out-of-pocket maximum is met.
4 If you choose a doctor who opts out of or does not accept assignment from Medicare, your doctor may be allowed to bill you for additional costs.
5 Includes Chiropractor and Therapy services.
6 Emergency Room copayment waived if admitted, but subject to hospital admission copayment.
7 See summary plan document for more information on covered services.
8 Includes CAT scans, MRI/MRA, PET scans, etc. See summary plan document for more information.

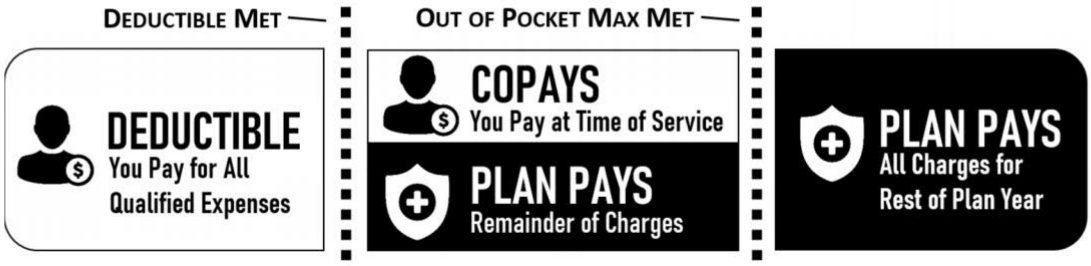
Medical Plan Deductible Structure

Cost Sharing

The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles and copayments, but it does not include premiums, balance billing amounts for non- network providers, or the cost of non-covered services.

Premium	Your premium is the amount you pay each pay period for your insurance coverage.
Deductible	At the start of each Plan Year, you pay for the cost of your health care before your State of Arizona health plan will pay.
Copayment/ Coinsurance	Once you have met your deductible, you will share in the cost of your health care with the State of Arizona. A copayment is the flat dollar amount that you will pay for health care services. Coinsurance is a percentage of the cost you will pay for health care services.
Out-of- Pocket Maximum	This amount is the most you will pay for health care services (not including premium). Once you have reached your out-of-pocket maximum, your State of Arizona health plan will pay 100% of all your covered services for the remainder of the Plan Year.

Deductible Structure



Tier 1 Deductibles (apply to Tier 2)			Tier 2 Deductibles (apply to Tier 1)		
Member $200	**Family $400**		**Member $1,000**	**Family $2,000**	
Member meets **$200** in expenses then member begins paying copays	Any 1 Member meets **$200** in expenses ALONE then member begins paying copays	Other Members meet **$200** in expenses COMBINED Other members begin paying copays	Member meets **$1,000** in expenses then member begins paying copays	Any 1 Member meets **$1,000** in expenses ALONE then member begins paying copays	Other Members meet **$1,000** in expenses COMBINED Other members begin paying copays

Network Options Outside Arizona

The chart below indicates the coverage options and Networks for members who live out-of-state. Both medical Networks offer statewide and nationwide coverage and are not restricted to regional areas. All plans are available in all domestic locations. However, not all plans have equal provider availability, so it is important to check with your current provider to determine if he/she is contracted with your selected Medical Network.

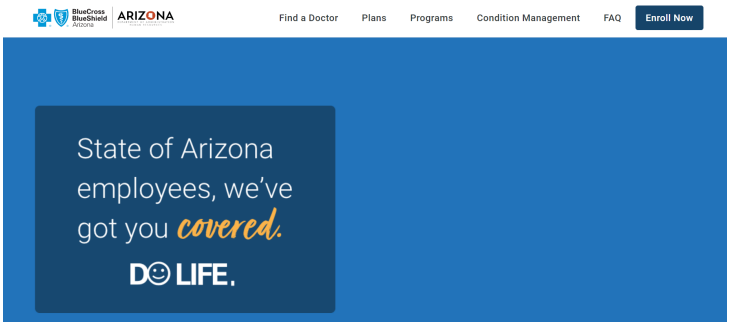
Carrier Network	Arizona	National
Blue Cross Blue Shield of Arizona	Blue Preferred Care / PPO as listed on medical card	Blue Preferred Care / PPO as listed on medical card
UnitedHealthcare	UHC Choice Plus Plan as listed on medical card	UHC Choice Plus Plan as listed on medical card

Medical Website Features

You can review your personal profile, view the status of medical claims, obtain general medical information, and learn how to manage your own healthcare through the available health plan websites.

Blue Cross Blue Shield of Arizona

Non-member: azblue.com/stateofaz
Existing member: azblue.com



Lookup Provider
Use this tool to find out if your doctor, hospital, retail clinic, or urgent care provider is contracted with Blue Cross Blue Shield of Arizona.

Blue Cross Blue Shield of Arizona members can create a user ID and password to have access to:

ID Card
Order a new ID card or print a temporary one.

Care Comparison
This simple online tool gives you access to price ranges for many common health care services right down to the procedure and the facility in your area. You can also view cost information across many specialties including radiology, orthopedics, obstetrics, and general surgery.

Hospital Compare
In this tool, you will find information on how well hospitals care for patients with certain medical conditions or surgical procedures, and results from a survey of patients about the quality of care they received during a recent hospital stay.

Claims Inquiry
View and read the detailed status of all medical claims submitted for payment. You can also obtain your Explanation of Benefits (EOB) or Member Health Statement.

Optional Electronic Paperless EOB
Reduce mail, eliminate filing and help the planet by going green.

Coverage Inquiry
Verify eligibility for you and your dependents.

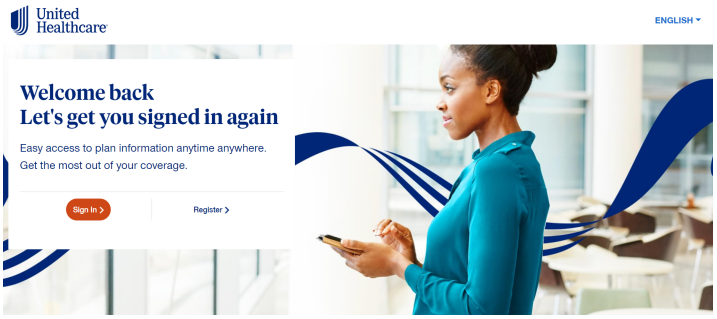
Wellness Tools
You can access wellness information through your personal HealthyBlue homepage.

Online Forms
You can find important forms and information online, including a medical claim form and medical coverage guidelines.

Help
You can find information on how to contact Blue Cross Blue Shield of Arizona regarding your benefits, claims, or any other questions you may have.

UnitedHealthcare

Non-member: whyuhc.com/stateofaz
Existing member: [myuhc.com®](myuhc.com)



From this site, you can access benefit information, learn about available tools, resources and programs, view open enrollment materials and more.

- View and compare benefit plan options
- Learn more about wellness programs, specialized benefits and online tools
- Search for physicians, facilities, and access our site for members, myuhc.com.

Need a new doctor or a specialist?
You can search for doctors near you and even see which doctors have been recognized by the UnitedHealth Premium® program for quality and cost-efficiency.

Your health, your questions, your myuhc.com
Once you become a member, your first stop is your member website, myuhc.com. It's loaded with details on your benefit plan and much more.

ID Card
Order a new ID card or print a temporary one.

Want to get rid of that nagging pain, but worried about the cost?
You can see what a treatment or procedure typically costs and see what your share of expenses may be.

Looking for an easier way to manage claims?
You can track claims, mark claims you've already paid, and review graphs to better understand what you owe. You can even make claim payments online.

Stay healthy with innovative health and wellness tools.

- Wellness tools and health checklists give you tips on living healthy and using health plan benefits to your advantage.
- Get reminders when it's time for checkups. Plus, get suggestions for other covered services, like immunizations, well-visits, routine tests, or lab work.
- Pursue your health goals. Through exciting interactive tools, you can participate in missions and have fun while focusing on wellness.
- Sync your wearable devices- like Fitbit® or Apple Watch® –for accurate reporting and results. You can even earn coins to enter for a chance to win a prize!

Always on the go? We can help you there too.
Whether you need to find urgent care, you forget your health plan ID card, or need to call customer service, the UnitedHealthcare Health4Me™ mobile app helps put your insurance information in the palm of your hand.

Medical Management

Services Available

When you choose Benefit Options medical insurance you get more than basic healthcare coverage. You get personalized medical management programs at no additional cost. Under the Benefit Options health plan, the medical Network you select during open enrollment serves their specific members.

Professional, experienced staff work on your behalf to make sure you are getting the best possible care and that you are properly educated on all aspects of your treatment.

Utilization Management

Each Medical network provides prior authorization and utilization review for the ADOA Benefit Options plans when members require non-primary care services. Prior to any elective hospitalization and/or certain outpatient procedures, you or your doctor must contact your medical Network for authorization. Please refer to your Plan Document for the specific list of services that require prior authorization. Each Network has a dedicated line to accept calls and inquiries:

- Blue Cross Blue Shield of Arizona 1-800-232-2345 ext. 4320
- UnitedHealthcare 1-800-896-1067

Case Management

Case management is a collaborative process whereby a case manager from your selected medical Network works with you to assess, plan, implement, coordinate, monitor, and evaluate the services you may need. Often case management is used with complex treatments for severe health conditions. The case manager uses available resources to achieve cost effective health outcomes for both the member and the State of Arizona.

Disease Management

The purpose of disease management programs is to educate you and/or your dependents about complex or chronic health conditions. The programs are typically designed to improve self-management skills and help make lifestyle changes that promote healthy living.

The following disease management programs are available to all Benefit Options members regardless of their selected Networks:

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Pregnancy/Maternity
- Coronary Artery Disease
- Healthy Back

If you are eligible or become eligible for one of the programs above, a disease manager from your selected Network will assess your needs and work with your physicians to develop a personalized plan.

Your personalized plan will establish goals and steps to help you to positively change your specific lifestyle habits and improve your health.

Your assigned disease manager may also:

- Provide tips on how to keep your diet and exercise program on track
- Help you to maintain your necessary medical tests and annual exams
- Offer tips on how to manage and control stress along with the associated symptoms.
- Assist with understanding your doctor's treatment plan
- Review and discuss medications, how they work and how to use them

Generally, a disease manager will work with you as quickly or as slowly as you like - allowing you to complete the program at your own pace. Over the course of the program, participants learn to incorporate healthy habits and improve their overall health.

Getting Involved

The Benefit Options disease management programs offered through each medical Network identify and reach out through phone calls and/or mail to members who may need help managing their health conditions.

The medical Networks work with the Benefit Options plan to provide this additional service. Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their respective medical Networks directly to self-enroll.

Please refer to your medical Network's phone number on pg. 61 if you or your dependent is interested.

NurseLine

A dedicated team of nurses, physicians, and/or dietitians are available 24/7 for member consultations. Members needing medical advice or who have treatment questions can call the toll-free NurseLine:

Blue Cross Blue Shield of Arizona 1-866-422-2729, Option 9
UnitedHealthcare 1-800-401-7396

Pre-Medicare Pharmacy Plan Information

MedImpact

If you elect any Benefit Options medical plan, MedImpact will be the Network you use for pharmacy benefits. Enrollment is automatic when you enroll in the medical plan.

MedImpact currently services 50 million members nationwide, providing prescription drug clinical services, benefit design, and claims processing since 1989 through a comprehensive Network of pharmacies.

ID Card

You will not receive a pharmacy ID card. The MedImpact Customer Care information can be found on the back of the ID card provided by your medical network.

How it Works

All prescriptions must be filled at a Network pharmacy by presenting your medical card. You can also fill your prescription through the mail order service. The cost of prescriptions filled out-of-Network will not be reimbursed.

No international pharmacy services are covered. Be sure to order your prescriptions prior to your trip and take your prescriptions with you.

The MedImpact plan has a three-tier formulary described in the chart on pg. 32. The copays listed in the chart are for a 31-day supply of medication bought at a retail pharmacy.

Formulary

The formulary is the list of medications chosen by a committee of doctors and pharmacists to help you maximize the value of your prescription benefit. These generic and brand name medications are available at a lower cost. The use of non-preferred medications will result in a higher copay. Changes to the formulary can occur during the plan year. Medications that no longer offer the best therapeutic value for the plan are deleted from the formulary. Ask your pharmacist to verify the current copay amount at the time your prescription is filled.

To see what medications are on the formulary, go to benefitoptions.az.gov or contact the MedImpact Customer Care Center and ask to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the best value, which saves money for you and your plan.

Finding a Pharmacy

To find a pharmacy refer to benefitoptions.az.gov. See online features for more information.

The MedImpact Customer Care Center is available 24 hours a day, 7 days a week. The toll-free telephone number is 1-888-648-6769.

Pharmacy Mail Order Service

MedImpact Direct is a convenient and less expensive mail order service available for retirees who require medications for ongoing health conditions or who will be in an area with no participating retail pharmacies for an extended period.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician.
- Request up to a 90-day supply of medication for two copays.
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at medimpact.com/plan/adoa/ or via phone at 855-873-8739. Have your insurance card ready when you call.

MedImpact Direct Mail

With this program, members who require medications for an on-going health condition can obtain a 90-day supply of medication at a local retail pharmacy for two and a half copays. For more information, contact MedImpact Customer Care Center at 1-888-648-6769.

Medication Prior Authorization

Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription. These prescriptions may be limited to quantity, frequency, dosage or may have age restrictions. The authorization process may be initiated by you, your local pharmacy, or your physician by calling MedImpact at 1-888-648-6769.

Step Therapy Program

Step Therapy is a program which promotes the use of safe, cost-effective and clinically appropriate medications. This program requires that members try a generic alternative medication that is safe and equally effective before a brand name medication is covered. For a complete list of drugs under this program, please refer to the formulary at benefitoptions.az.gov.

Specialty Pharmacy Program

Certain medications used for treating chronic or complex health conditions are handled through the AllianceRx Walgreens Prime Specialty Pharmacy Program. This program assists you with monitoring your medication needs and provides patient education.

Specialty medications are limited to a 31-day supply and may be obtained only through the MedImpact Direct Specialty facility by calling 1-888-782-8443.

Limited Prescription Drug Coverage

Prescription drug coverage will generally be limited to medications that do not have an equally effective over-the-counter substitute.

Non-Covered Drugs

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

Extended Vacation or Travel Abroad

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify MedImpact in writing of why you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone. MedImpact will be able to authorize a VACATION OVERRIDE allowing you to have extra medication you will need provided you have the appropriate number of refills remaining.

Order refills at least two weeks in advance of your departure. If there is a problem, such as, not enough refills, you will have enough time to phone your physician. If you're using Mail Order, contact MedImpact at least three weeks in advance.

If you are already out of town and need a prescription, call MedImpact. Tell the representative you are out of town and need to find a participating pharmacy in the area where you are. You will need the zip code where you are visiting. In most cases you will have several choices.

If your medication is lost, stolen, or damaged, replacement medication is not covered.

Contacts

MedImpact	
Customer Care Center and PriorAuthorization	1-888-648-6769
MedImpact BIN Number	003585
Retail PCN Number	28914

MedImpact Direct	
Mail Order	1-866-304-2846
Specialty Pharmacy	1-877-391-1103

Pre-Medicare Pharmacy Co-Pays

Co-Pays – Pre-Medicare Pharmacy Plan			
	Generic	**Preferred Brand Name**	**Non-Preferred Brand Name**
Retail 30 Days	**$15**	**$40**	**$60**
Retail 90 Days	**$37.50**	**$100**	**$150**
Mail Order 90 Days	**$30**	**$80**	**$120**

NAU Retiree BCBS Members only

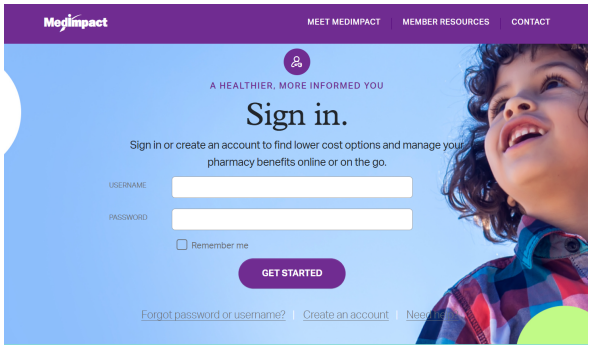
There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic, preferred brand, non-preferred brand A, or non-preferred brand B copay.

The BCBSAZ Prescription Medication Guide can be used to determine your copay and this guide can be found on the BCBS website at bcbsaz.com. View the four level chart for prescription drug benefits.

Up to a 90-day supply of maintenance drugs (the same drug and drug strength) may be obtained through the Mail-Order Program. Maintenance drugs are drugs you take consistently. The copay for the 90-day supply is equivalent to one month's copay for Level 1 and Level 2 Prescriptions and equal to two copays for Level 3 and Level 4 prescriptions.

Pre-Medicare Pharmacy Website Features

Members can view pharmacy information on medimpact.com/plan/adoa
Generic Login to Preview Formulary - Username: EPOADOA3, Password: Arizona202!



Members can create a username and password to have access to:

Benefit Highlights
View your current copay amounts and other pharmacy benefit considerations.

Formulary Lookup
Research medications to learn whether they are generic, preferred or nonpreferred drugs. This classification will determine what copay is required. You can search by drug name or general therapeutic category.

Prescription History
View your prescription history, including all the medications received by each member, under PersonalHealth Rx. Your prescription history can be printed for annual tax purposes.

Drug Search
Research information on prescribed drugs like how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.

Health & Wellness
Learn valuable tips and information on diseases and health conditions.

Mail Order
A link will direct you to the MedImpact Direct website where you may register for mail order service by downloading the registration form and following the step-by- step instructions.

Locate a Nearby Pharmacy
Locate a pharmacy near your home address, out-of-town vacation address, or your dependent's address.

Generic Resource Center
Learn more about generic drugs and savings opportunities.

Choice90
Learn more about the Choice90 option. With this program, you can obtain a 90-day supply of medication for a reduced copay.

NAU Retirees
Blue Cross Blue Shield Members Only
Refer to more information by accessing Blue Net, Blue Cross Blue Shield of Arizona's online member website at bcbsaz.com.
Information on the pharmacy plan and copay levels for prescriptions can be found at bcbsaz.com. Go to 4-level prescription drug benefit

Medicare Pharmacy Plan Information

VibrantRx (Employer PDP)

For Medicare eligible retirees & Medicare eligible dependents. If you elect any Benefit Options medical plan, you will be automatically enrolled in VibrantRx for Benefit Options.

Enrollment in this plan depends on contract renewal. All VibrantRx communications will include the VibrantRx logo.

How it Works

Medicare-eligible retirees and their Medicare-eligible dependents enrolled in VibrantRx will each receive their own prescription drug ID card.

The new ID card will be issued by VibrantRx, and will NOT replace your medical card. The new prescription drug ID card is in addition to your medical card. Show your VibrantRx card when you fill your prescription medications at the pharmacy.

Members will need to use their new VibrantRx prescription ID card if they're enrolled in VibrantRx Part D Prescription Drug Program for Benefit Options. Members will receive their new card within 10 days of their effective date.

All prescriptions must be filled at a Network pharmacy by presenting your VibrantRx prescription ID card. You can also fill your prescription through the Walgreens mail order service.

The VibrantRx for Benefit Options plan has a four-tier formulary.

The Plan provides you full coverage so there is no Coverage Gap, or "Donut Hole." This allows your cost sharing to remain consistent. You pay the same copays throughout the year during all the Medicare Part D stages.

If you reach the catastrophic coverage stage ($5,000 in total out-of-pocket costs for 2022), your Benefit Options copayment will be the maximum amount charged.

Benefits, formulary pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year.

This information is not a complete description of benefits. Contact the plan for more information. Limitations,

copayments, and restrictions may apply. For more information contact VibrantRx.

Formulary

The formulary is the list of medications chosen by a committee of doctors and pharmacists to help maximize the value of your prescription benefit.

Members will use VibrantRx's four-tier formulary. Generic and brand name medications are available at a lower cost. Generally, your formulary will not change during the year except for cases in which you can save additional money or to ensure your safety. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective.

Medicare Prescription Drug Plan Copays			
Tier Number / Name	**Retail (up to 31-day supply)**	**Mail Order (up to 90-day supply)**	**Choice90Rx Extended supply at retail (up to 90-day supply)**
Tier 1: Generic	$15	$30	$37.50
Tier 2: Preferred Brand	$40	$80	$100
Tier 3: Non-Preferred Brand	$60	$120	$150
Tier 4: Specialty - Over $670[1]	$60	Not available	Not available

[1] *Total medication cost*

Some drugs may have additional requirements or limits on coverage. These requirements and limits may include:

Prior Authorization

Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription. You or your physician will need to obtain approval from VibrantRx before these drugs can be covered by the plan.

Step Therapy Program

The program promotes the use of safe, cost-effective and clinically appropriate medications. This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "step therapy".

Quantity Limits

For certain drugs, VibrantRx limits the amount of the drug that VibrantRx will cover. To see what medications are on the formulary and get additional information about drug restrictions, go to myvibrantrx.com/stateofaz or call VibrantRx's Member Services at 1-844-826-3451. TTY users should call 711. Member Services are available 24 hours a day, 365 days a year. Sharing this information with your doctor helps ensure you are getting the best value, which saves money for you and your plan.

The formulary may change at any time. You will receive notice when necessary.

Finding a Pharmacy

VibrantRx has over 65,000 pharmacies in its network. Members may continue to fill their prescriptions at their current pharmacy if it is a VibrantRx for Benefit Options network pharmacy.

Members may request a pharmacy directory from Member Services or use the online Pharmacy Locator at myvibrantrx.com/plan/stateofaz.

The pharmacy network may change at any time. You will receive notice when necessary.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for members who need medications for ongoing health conditions or who will be in an area with no participating retail pharmacies for an extended period.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician, but verification is required every 30 days.
- Auto refill is not available.
- Request up to a 90-day supply of medication for two copays. (Example: A 31-day supply retail prescription for a $10 copay versus a 90-day supply mail order prescription for a $20 copay.)
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at medimpact.com/plan/adoa/ or via phone at 855-873-8739. Have your prescription card ready when you call.
- You may also use the mail order form found on benefitoptions.az.gov/forms.

Choice90Rx

With this program, members who require medications for an ongoing health condition can obtain a 90-day supply of medication at a local retail pharmacy for two and a half copays.

For more information or to find a participating Choice90Rx pharmacy, please visit our website at myvibrantrx.com/stateofaz, refer to your Pharmacy Directory or call VibrantRx Member Services at 1-877-633-7943, 24 hours a day/365 days a year. TTY/TDD users should call 711.

Specialty Pharmacy Program

If you are taking a medication that is on the Specialty tier of your prescription benefit, you may use MedImpact Direct Specialty pharmacy, or any specialty pharmacy in the VibrantRx specialty pharmacy network.*

*Other pharmacies are available in our network. To enroll in AllianceRx Walgreens Prime Specialty Pharmacy's Patient Care Programs, please call 1-888-782-8443 to speak with a Patient Care Coordinator. AllianceRx Walgreens Prime Specialty Pharmacy will reach out to your health care provider to get a new prescription for you or have your specialty prescriptions transferred from your current pharmacy. For more information on AllianceRx Walgreens Prime Specialty Pharmacy, visit alliancerxwp.com.

Specialty medications are limited to a 31-day supply.

Under Medicare Part D

Extra Help (Low Income Subsidy)

Eligible retirees and their dependents with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for up to 100% of drug costs including

coinsurance/copayments.

Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many Medicare eligible retirees and their dependents are eligible for these savings and don't even know it.

Members eligible for "Extra Help" are identified during the enrollment process. Plan participants that are eligible will receive a Low-Income Subsidy (LIS) Rider with their Explanation of Coverage explaining what their benefit will be.

For more information about Extra Help, members may contact their local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days a week. TTY/TDD users should call 1-877-486-2048, or visit medicare.gov.

Part D Income Related Monthly Adjustment Amount (IRMAA)
Some Medicare eligible members and their dependents pay an extra amount for Part D because of their yearly income. If a member's modified adjusted gross income is $85,001 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, they must pay an extra amount directly to the government (not the Medicare plan) for Medicare Part D coverage.

- If a member is required to pay the extra amount and does not pay it, they will be disenrolled from the plan and lose prescription drug coverage.
- If the member needs to pay an extra amount, Social Security, not the Medicare plan, will send the member a letter telling them what that extra amount will be.
- For more information about Part D premiums based on income, visit medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Members may also call Social Security at 1-800-772-1213.
- TTY users should call 1-800-325-0778.

The booklet *Medicare & You 2022* gives information about the Medicare premiums in the section called "2022 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for Medicare eligible members and their dependents with different incomes.

Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of Medicare & You 2022 from the Medicare website (medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members also pay a premium for Medicare Part B.

Members who owe the income-related monthly adjustment amount (IRMAA or "extra amount") will receive a letter directly from the Social Security Administration (SSA). VibrantRx is not aware whether the member qualifies for this additional premium or not as it is managed strictly through the SSA.

VibrantRx is only made aware of IRMAA if the member is disenrolled for non-payment. See Ch. 4, Section 11 of the Evidence of Coverage for more information about the extra amount.

If a member feels they should not have to pay the additional premium, they should call the SSA number listed in the letter.

SSA will either make an appointment for the member at their local SSA office or they will transfer them to the local SSA phone number for an income re-determination. A member's income may have increased/decreased due to capital gains (e.g. sale of a home, cashing in a 401k, marriage, divorce or death).

Extended Vacation or Travel Abroad

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need.

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify VibrantRx in writing of why you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone.

VibrantRx will generally be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need provided you have the appropriate number of refills remaining. Order refills at least two weeks in advance of your departure. If there is a problem, such as, not enough refills, you will have enough time to phone your physician. Copays will be the same as you would normally pay times the number of refills you need.

VibrantRx cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

Contact Information

VibrantRx Member Services are available to address pharmacy plan questions. Representatives are available 24 hours a day, 365 days a year at 1-877-633-7943. TTY users should call 711. Language translation services are available.

Pharmacies and providers may call the VibrantRx Pharmacy and Provider Help Desk at 1-888-678-7789. Representatives are available 24 hours a day, 365 days a year. TTY users should call 711.

To view your VibrantRx for Benefit Options plan benefits, find a participating pharmacy or look up the price of your drugs, visit myvibrantrx.com/stateofaz.

iRx Discount Program

You may be able to obtain a discount on certain brand and generic medications that are not covered by your ADOA pharmacy drug plan, through the iRx Program™. Present your VibrantRx ID card at any participating pharmacy, along with your prescription for the medication. Savings are applied automatically when the item prescribed qualifies for a discount. The amount of the discount will vary based on the pharmacy chosen and type of medication.

Medicare has neither reviewed nor endorsed this information.

Medicare Pharmacy Website Features

Members can view pharmacy information at
myvibrantrx.com/stateofaz

Members can create a username and password to have access to:

Benefit Highlights
View your current copayments and other pharmacy benefit considerations.

Prescription History
View your prescription history, including all the medications received by each member, under PersonalHealth Rx. Your prescription history can be printed for annual tax purposes.

Drug Price Check
Review prescription choices and compare drug prices. Search by drug name to view formulary status, tier and cost.

Mail Order
A link will direct you to register for mail order service by downloading the registration form and following the step-by-step instructions. Auto refill is not available.

Locate a Nearby Pharmacy
Locate a pharmacy near your home address, out-of-town vacation address, or your dependent's address.

Generic Drug Resource Center
Learn more about generic drugs and savings opportunities.

Dental Plan Information

Retirees may choose between two plan types: the Prepaid/DHMO and the Preferred Provider Organization (PPO) plans. Each plan's notable features are listed below.

Cigna Dental Access

- You MUST use a Cigna Dental Care Access Participating Dental Provider to provide and coordinate all of your dental care
- No annual deductible or maximums
- No waiting periods
- Pre-existing conditions are covered
- Specific copays for services
- Specific lab fees for prosthodontic materials

Each family member may choose a different general dentist from the DHMO provider network. You can select or change your dentist by contacting Cigna by telephone. Members may self-refer to dental specialists within the Network. Specialty care copays are listed in the Patient Charge Schedule. Specialty services not listed are provided at a discounted rate. This discount includes services at a Periodontist, Prosthodontist, and TMJ care.

Availability: The Cigna DHMO is not available if you reside in the following states: AK, ID, ME, MT, NH, NM, ND, PR, SD, VT, USVI, WV and WY.

PPO Plan: Delta Dental PPO plus Premier

As a State of Arizona eligible member, you can enroll in the Delta Dental of Arizona – PPO plus Premier plan with covered preventive services.

- Your preventive and diagnostic services are covered at 100% and are not subtracted from your annual maximum
- Your annual maximum benefit is $2,000 per benefit year
- No deductible for diagnostic and routine services
- $50 deductible per person and no more than $150 per family
- The maximum lifetime benefit for orthodontia is $1,500
- A third dental cleaning per benefit year is available for eligible members
- A no-missing-tooth clause is included
- You can elect to see a licensed dentist anywhere in the world
- Delta Dental has the largest network in Arizona with 3,200+ participating dentists
- You can maximize your benefits when you select a PPO Provider
- Delta Dental dentists have agreed to accept a negotiated fee (after deductibles and copays are met) and in most circumstances, cannot balance bill you more than the allowed fee
- Claims are filed by the network dentist and are paid directly, making it easier for you.

To find a Delta Dental dentist near you, please visit deltadentalaz.com/find.

ID Card

New enrollees should receive a card within 10-14 business days after the benefits become effective.

How to Choose the Best Dental Plan for You

When choosing between a Prepaid/DHMO plan and an Indemnity/PPO plan, you should consider the following: dental history, level of dental care required, costs/budget and provider in the Network. If you have a dentist, make sure he/she participates in the plan (Prepaid/DHMO plan – Cigna Dental or Indemnity/PPO - Delta Dental PPO plus Premier) you are considering.

For a complete listing of covered services for each plan, please refer to the plan description located on the website: benefitoptions.az.gov.

Dental Plans Comparison Chart

The chart below is a comparison of in-Network services only which are subject to all provisions, terms and conditions of the Plan Description or Patient Charge Schedule. For a complete list of benefits coverage and out-of-Network services, view the Summary Plan Descriptions on **benefitoptions.az.gov**. Carrier contact information and policy numbers are on the back cover.

Plan Type		Dental Care Access[1]	PPO Plus Premier
Carrier		Cigna	DELTA DENTAL
Dental Premiums Per Month			
Retiree Only		**$8.52**	**$35.94**
Retiree + Adult		**$17.04**	**$75.63**
Retiree + Child		**$16.59**	**$60.48**
Retiree + Family		**$25.54**	**$118.26**
Retiree Cost For Care			
Plan Year Deductibles		None	$50/$150
Annual Combined Basic and Major Services		No Dollar Limit	$2,000 per person
Orthodontia Lifetime		No Dollar Limit	$1,500 per person
Preventive Care Class I	**Oral Exam**	$0	$0 - Deductible Waived[2]
	Emergency Exam	$0 (treatment of pain) $55 (after hours office visit)	$0 - Deductible Waived[2]
	Prophylaxis/Cleaning	$0	$0 - Deductible Waived[2]
	Fluoride Treatment	$0	$0 (to age 18) - Deductible Waived[2]
	X-Rays	$0	$0 - Deductible Waived[2]
Sealants		$12 per tooth	20% (to age 19)
Fillings		Amalgam: $0 | Resin: $0	20%
Extractions		Simple: $12 Surgical $53	20%
Periodontal Gingivectomy		$91, 1 to 3 teeth $180, 4 or more teeth	20%
Oral Surgery		$12 - $850	20%
Crowns		$150 -$500	50%
Dentures		$680 upper & lower	50%
Fixed Bridgework		$135 per unit	50%
Crown/Bridge Repair		$490	50%
Implant Body		$1,025	50%[3]
Orthodontia		24-mo. treatment fee, see charge sched	50%[4]
Other Services	**TMJ Exam/Services**	$330 Occlusal orthotic device	Not covered
	External Bleaching	$165	Not covered

1 The Cigna plan is not available in AK, ID, ME, MT, NH, NM, ND, PR, SD, VT, USVI, WV, and WY.

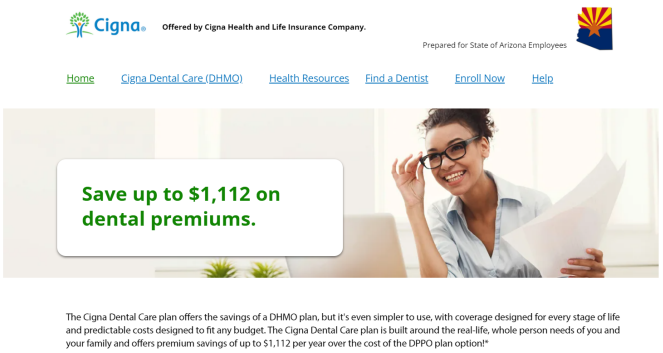
2 Routine visits, exams, cleanings and flouride treatments are covered two times per Plan Year at 100%. Emergency exams are covered once per Plan Year at 100%. X-rays (Bitewing, Periapicals) are covered once per Plan Year at 100%.

3 Subject to both the benefit year allowance and the lifetime maximum limit of $1,000 per tooth. Subject to all provisions, terms, and conditions of the Plan Description.

4 Limited to a lifetime maximum of $1,500 per member.

Dental Website Features

Cigna Dental Care Access
view.ceros.com/cigna/stateofaz/



For members enrolled in the Cigna plan: visit the site for access to:

Personal Profile
You can verify your coverage, copays, deductibles, and view the status of claims.

ID Card
Order a new ID card or print a temporary one.

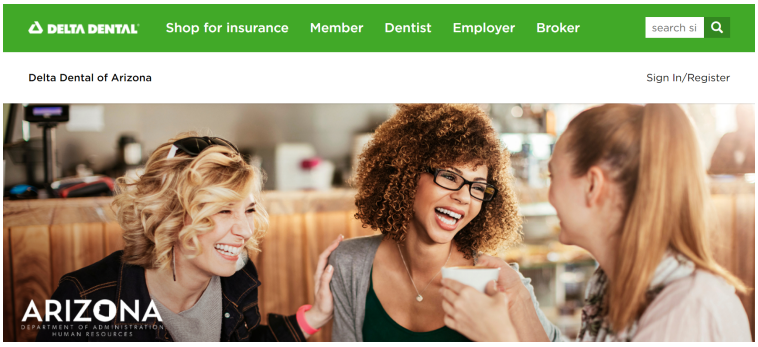
Find Dentists and Services
View dental office features, procedures, and costs.

Conduct Research
With an interactive library, you can gather information on health conditions, first aid, medical exams, wellness, and more.

MyCigna Mobile App
You can download a free, personalized smartphone app. From there, you can do almost anything on the go – from getting your ID cards, account balances, locating dental providers, and so much more. Get the MyCigna Mobile app today!

Cigna Dental Care Access Plan Availability
The Cigna Dental Care Access Plan is not available if you reside in the following states: AK, MI, ME, MT, NH, NM, ND, PR, RI, SD, VT, WV and WY.

Delta Dental PPO plus Premier
deltadentalaz.com/adoa



Delta Dental PPO plus Premier
Managing your benefits online is easy and convenient with Delta Dental! After the benefit year begins on January 1, please visit deltadentalaz.com to create your ID and password in the Member Connection, a secure website that gives you access to the following tools and materials:

View and/or print your benefits and eligibility

Go paperless and sign up for electronic Explanation of Benefits (EOBs) 24/7 claims information: Check your claims by dates, print copies of EOBs for you or your dependents, or download a claim form.

Use the Find a Dentist tool to search Delta Dental's national dentist directory Plus:

- Download the Delta Dental Mobile App (iOS and Android) to access your ID card, view coverage and claims details, or find a dentist from your phone or tablet
- Check out the Delta Dental of Arizona Blog at deltadentalazblog.com for oral health articles and tips
- Assess your risk for dental diseases with the Oral Health Assessment Tool at MyDentalScore.com/DeltaDenta

Vision Plan Information

Coverage for vision is available through the Avesis Advantage Program.

Avesis Advantage Program

Retirees are responsible for the full premium of this voluntary plan.

Program Highlights

- Yearly coverage for a vision exam, glasses or contact lenses
- Extensive provider access throughout the state
- Unlimited discounts on additional optical purchases.

How to Use the Advantage Program

1. Find a provider – You can find a provider using the Avesis website avesis.com or by calling customer service at 1-888-759-9772. Although you can receive out-of-Network care as well, visiting an in-Network provider will allow you to maximize your vision care benefit.
2. Schedule an appointment – Identify yourself as an Avesis member employed by the State of Arizona when scheduling your appointment.

Out-of-Network Benefits

If services are received from a non-participating provider, you will pay the provider in full at the time of service and submit a claim to Avesis for reimbursement. The claim form and itemized receipt should be sent to Avesis within three months of the date of service to be eligible for reimbursement. The Avesis claim form can be obtained at the website avesis.com. Reimbursement will be made directly to the member.

Availability

Vision coverage is available only if you have medical or dental coverage with Benefit Options; it is not available as a stand-alone policy. It is not subsidized by ASRS, nor deducted from your pension.

Quarterly Billing

- Avesis bills you directly for the quarterly premium on January 15, April 15, July 15 and September 15.
- Failure to remit your premium payment to Avesis by the due date will result in cancellation of your vision benefits. There are no premium refunds for dropped coverage.

2022 Invoice and Payment Schedule

Billing Cycle	Invoice Date	Premium Due Date
1st Quarter - Jan, Feb, Mar	**1/14/2022**	**2/28/2021**
2nd Quarter - Apr, May, Jun	**3/18/2022**	**4/29/2022**
3rd Quarter - Jul, Aug, Sep	**6/20/2022**	**7/29/2022**
4th Quarter - Oct, Nov, Dec	**9/20/2022**	**10/31/2022**

Refractive Surgery Benefit

LASIK surgery benefits are available to Advantage Program or Discount Program members. To find a LASIK provider - visit avesis.com/arizona or call 1-888-759-9772.

Target Optical Discount

You will receive $25 on frames when using Target Optical services located within Target Stores.

Avesis Discount Hearing Plan

If you are enrolled in the Advantage Program, members have access to a new Hearing Discount Plan. To utilize the Hearing Discount Plan, call 1-866-956-5400 and identify yourself as an Avesis member employed by the State of Arizona to access your benefits.

For a complete listing of covered services please refer to the plan descriptions at benefitoptions.az.gov.

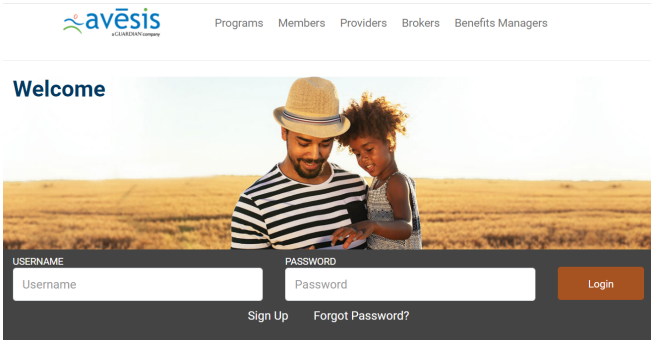
Plan Services and Premiums – The chart below lists in-Network services only. For a complete list of other benefits coverage, view the Plan Policy on **benefitoptions.az.gov**.

Vision Plan Premiums – Quarterly		Advantage Program
Retiree Only		**$11.16**/QUARTER
Retiree + Spouse		**$37.08**/QUARTER
Retiree + 1 Child		**$36.72**/QUARTER
Retiree + Family		**$46.20**/QUARTER
Retiree Cost For Care		
Routine Eye Examination Copay (One per Plan Year)		$10
Optical Materials Copay (Lenses & Frame Combined)		$0
Standard Spectacle Lenses (One per Plan Year)	**Single Vision Lenses**	Covered in-full
	Bifocal Lenses	Covered in-full
	Trifocal Lenses	Covered in-full
	Lenticular Lenses	Covered in-full
	Progressive Lenses	Uniform discounted fee schedule
	Select Lens Tints/Coatings	Uniform discounted fee schedule
Frame (One per Plan Year)		Up to $150 retail value ($50 wholesale cost allowance)
Contact Lenses in lieu of frame/spectacle lenses Includes fitting, follow-up and materials	**Elective**	10-20% discount & $150 allowance
	Medically Necessary	Covered-in-full
LASIK/PRK		Up to $750
Target Optical Frame Discount (locations inside Target Stores)		$25

Vision Website Features

Avesis avesis.com/members.html

Login with your Employee ID Number (EIN) and create a password to have access



Search for Providers
Search for contracted Network providers near your location.

Benefit Summary
Learn about what is covered under your vision plan and how to use your vision care benefits.

Print an ID Card
If you lose or misplace your ID card, you can print a new one.

Verifying Eligibility
You can check your eligibility status before you schedule an exam or order new materials.

Plan Policy
You can view your plan policy.

Glossary
You can learn about vision terminology.

Facts on Vision
Learn about different vision facts.

Claim Form
You can obtain an out-of-Network claim form.

International Coverage

MEDICAL CARE	
TripleOption Plan	
Only emergency services are available for international coverage. All services must be verified by a Third Party Administrator.	
NAU Only	
Blue Cross Blue Shield PPO	For assistance with locating a provider and submitting claims, call 1-800-810-2583 or 1-804-673-1686. For an international claim form *bcbsglobalcore.com*
PHARMACY	
MedImpact	Not covered
DENTAL CARE	
Cigna Dental Care Access	
Cigna Dental	Emergency Only
PPO Plan	
Delta Dental PPO plus Premier	Coverage is available under non-participating provider benefits
VISION CARE	
Avesis	Covered as out-of-Network and will be reimbursed based on the Avesis reimbursement schedule

Long Term Disability

When receiving Long-Term Disability (LTD) benefits, for purposes of health, dental, and vision benefits, LTD members are considered “Retirees” and will fall under all premiums, processes and guidelines as retired members.

No Longer Eligible for LTD Benefits & Not Able to Retire

Your eligibility in the Benefit Options plan terminates at the end of the month in which you lose eligibility. You may wish to contact your retirement system to determine if you are eligible to enroll in their health plan. It is your responsibility to notify us when your LTD entitlement ends.

Returning to Work

Your return to work will be considered a Qualified Life Event. You must make your new benefit elections within 31 days of your return to work. Please contact your agency HR personnel for further instructions immediately after you lose your LTD eligibility status.

Waiver of Premiums

A Waiver of Premium only applies to life insurance and does not apply to your health, dental and vision benefits. Even if your life insurance premiums are waived, you are still responsible for payment of your medical, dental, and vision monthly premiums. Your Waiver of Premium eligibility is determined by the Life Insurance carrier.

Please contact your Life Insurance carrier with any questions and to learn if you are eligible for a Waiver.

Disability Benefits from Social Security & Eligibility for Medicare

If you have been receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months, you will be automatically entitled to Medicare Part A and Part B beginning the 25th month of the disability benefit entitlement. You will not need to do anything to enroll in Medicare.

Your Medicare card will be mailed to you about three months before your Medicare entitlement date. You must mail a copy of your Medicare card to the ADOA HR - Benefits within 31 days of receiving the card.

If you are under age 65 and have a disease such as Lou Gehrig’s Disease (ALS), you will be entitled to Medicare the first month you receive disability benefits from Social Security or the Railroad Retirement Board. For more information, call the Social Security Administration at 1-800-772-1213.

Receiving Social Security Disability

The Benefit Options health plans require all Medicare eligible members to enroll in both Part A (hospital insurance) and Part B (medical insurance). For more information, contact the Social Security Administration or the ADOA HR Division-Benefits.

Legal Notices

General COBRA Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other Members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the ADOA HR Division-Benefits.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child"

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Benefit Options Plan, and that bankruptcy results in a loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a qualified beneficiary. The Retired Employee's Spouse, Surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Health Insurance Marketplace Coverage Options & Your Health Coverage

General Information

When key parts of the health care reform law (the Affordable Care Act or ACA) take effect in 2014, there will be a new way to buy health insurance: through the health insurance marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new marketplaces and employment based health coverage offered by your employer.

What is the health insurance marketplace?

The marketplace is designed to help you find health insurance that meets your needs and fits your budget. The marketplace offers "one-stop shopping" to find and compare private health insurance options. You can enroll for health insurance coverage through the Marketplace during an enrollment period that begins in October 2013. Coverage can begin as early as January 1, 2014.

Can I save money on my health insurance premiums in the marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.69% of your household income for that year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the marketplace instead of accepting health coverage offered by your employer, then you will lose any employer contribution to the State of Arizona Benefit Options Plan. Also, this employer contribution – as well as your employee contribution to State of Arizona Benefit Options

Plan – is often excluded from income for Federal and State income tax purposes. Future enrollment in the State of Arizona Benefit Options Plan will be limited to open enrollment (which typically happens in the fall).

How can I get more information?
For more information about the coverage offered by your employer, please check your summary plan description or contact the Arizona Department of Administration HR Division - Benefits contact information included in the employer information chart.

The marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. Visit www.HealthCare.gov for more information, including an online application for health insurance coverage and a Health Insurance Marketplace in your area.

Information about health coverage offered by your employer
If you decide to complete an application for coverage in the marketplace, you will be asked to provide the information included in the chart below. This employer information is numbered to correspond to the marketplace application.

Employer Information - Numbers Correspond to the Marketplace Application	
3. Employer Name	State of Arizona
4. Employer Identification Number (EIN)	86-6004791
5. Employer Address	100 N 15th Ave, Suite 301
6. Employer Phone Number	(602) 542-5008
7. City	Phoenix
8. State	AZ
9. Zip Code	85007
10. Who can we contact about employee health coverage at this job?	HR - Benefits
12. E-mail Address	Benefits@azdoa.gov

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to some employees and dependents. Eligible employees and dependents are defined in the EPO, PPO and HSA plan descriptions (Article 3 Eligibility and Participation) posted on the Benefit Options website benefitoptions.az.gov
- This coverage provided meets the minimum value standard, and the cost of this coverage is intended to be affordable.

If you decide to shop for coverage in the marketplace, www.HealthCare.gov will guide you through the process. The employer information you can enter when you visit www.HealthCare.gov will help you determine if you can get a subsidy (in the form of a tax credit) to lower your monthly premiums for coverage purchased through the marketplace.

Newborns' & Mothers' Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or her newborn earlier. Also, under federal law, plans and insurers may not set the lever of benefits or out-of-pocket costs so that any later portion of the 48-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. If you have any questions, contact Benefit Options at 602-542-5008 or 1-800-304-3687 or email Benefit Options at benefits@azdoa.gov.

Nondiscrimination Notice

Benefit Options complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Benefit Options provides free aids/services to people with disabilities and to people who need language assistance.
If you need a qualified interpreter, written information in other formats, translation or other services, contact:

ADOA HR Division-Benefits
100 N. 15th Avenue, Suite 260
Phoenix, AZ 85007
602-542-5008 or 1-800-304-3687, or email benefits@azdoa.gov

If you believe that we have failed to provide these services or discriminated based on a protected class noted above, you can also file a grievance with the ADOA HR Division-Benefits.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 602-542-5008 o 1-800-304-3687.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 602-542-5008, 1-800-304-3687 hodíilnih.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 602-542-5008, 1-800-304-3687.

Patient Protection & Affordable Care Act (PPACA)

Notice of Rescission

Under the PPACA, the ADOA HR Division-Benefits cannot retroactively cancel or terminate an individual's coverage, except in cases of fraud and similar situations. In the event that the HR - Benefits rescinds coverage under the allowed grounds, affected individuals must be provided at least 30 days' advance notice.

Form W-2 Notice

Pursuant to the PPACA for tax years starting on and after January 1, 2012, in addition to the annual wage and tax statement employers must report the value of each employee's health coverage on form W-2, although the amount of health coverage will remain tax-free.

Notice about the Summary of Benefits and Coverage (SBC) and Uniform Glossary

On February 9, 2011, as part of the Affordable Care Act (ACA), the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations require group health plans and health insurance issuers that offer coverage for groups and individuals to provide access to the SBC and Uniform Glossary effective October 22, 2012. The SBC documents along with the uniform glossary will be posted electronically to the Benefit Options Website benefitoptions.az.gov. You may also contact HR-Benefits to obtain a copy.

Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage through the Benefit Options program and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage: Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

ADOA has determined that the prescription drug coverage offered by the Benefits Options Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Drug Plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Benefit Options coverage will be affected. If you enroll in a Medicare Part D Plan, you will not be eligible for Benefit Options medical coverage.

If you do decide to join a Medicare drug plan and drop your current Benefit Options coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Benefit Options and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
For further information contact ADOA HR - Benefits at 1-800-304-3687 or visit our website at benefitoptions.az.gov. Questions can also be sent to ADOA HR - Benefits via email at benefits@azdoa.gov.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if the coverage through Benefit Options changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov;
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help;
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

HIPAA Privacy Regulation Requirements
This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor and other parties as necessary to determine appropriate processing of claims.

Special Enrollment Rights for Health Plan Coverage

If you decline enrollment in the State of Arizona's health plan for you or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you or your Dependents may be able to enroll in the State of Arizona Employee's health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new Dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the State of Arizona's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your Dependent becomes eligible for special enrollment rights, you may add the Dependent to your current coverage or change to another health plan.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because the Plan health plan offers coverage for mastectomies, WHCRA applies to the Plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan.

No Surprises Act

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most that those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Blue Cross Blue Shield of Arizona at 1-866-287-1980 or www.azblue.com; or, UnitedHealthcare at 1-800-896-1067 or www.myuhc.com.

Glossary

Appeal
A request to a plan provider for review of a decision made by the plan provider.

Balance Billing
A process in which a member is billed for a provider's fee that remains unpaid by the insurance plan. You should never be balance billed for an in-Network service; out-of-Network services and non-covered services are subject to balance billing.

Beneficiary
The person(s) you designate to receive your life insurance (or other benefit) in the event of your death.

Brand Name Drug
A drug sold under a specific trade name as opposed to being sold under its generic name. For example, Motrin is the brand name for ibuprofen.

Case Management
A process used to identify members who are at risk for certain conditions and to assist and coordinate care for those members.

Centers for Medicare & Medicaid Services (CMS) The Federal agency that administers Medicare. You may contact Medicare at 1-800-MEDICARE (1-800-633-4227) or medicare.gov.

Claim
A request to be paid for services covered under the insurance plan. Usually the provider files the claim but sometimes the member must file a claim for reimbursement.

COBRA (Consolidated Omnibus Budget Reconciliation Act)
A federal law that requires larger group health plans to continue offering coverage to individuals who would otherwise lose coverage. The member must pay the full premium amount plus an additional administrative fee.

Coinsurance
A percentage of the total cost for a service/prescription that a member must pay after the deductible is satisfied.

Coordination of Benefits (COB)
An insurance industry practice that allocates the cost of services to each insurance plan for those members with multiple coverage.

Copay
A flat fee that a member pays for a service/prescription.

Coverage Gap (Donut Hole)
VibrantRx for Benefit Options does not have a donut hole. You will continue to pay the same costs throughout the plan year.

Creditable Coverage
Prescription drug coverage (for example, from an employer) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible
Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copays and/or coinsurance amounts may or may not apply. (See comparison charts on pg. 21).

Dependent
An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Refer to pg. 6 for eligibility requirements.

Disease Management
A program through which members with certain chronic conditions may receive educational materials and additional monitoring/support.

Disenrollment
The process of ending your membership in the Benefit Options medical and pharmacy plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug Tier
Every drug on the list of covered drugs (formulary) is in a drug tier. In general, the higher the drug tier, the higher your cost for the drug.

Emergency
A medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

EPO (Exclusive Provider Organization)
A type of health plan that requires members to use in-Network providers.

Exclusion
A condition, service, or supply not covered by the health plan.

Explanation of Benefits (EOB)
A statement sent by a health plan to a covered person who files a claim. The explanation of benefits (EOB) lists the services provided, the amount billed, and the payment made. The EOB statement must also explain why a claim was or was not paid, and provide information about the individual's rights of appeal.

Formulary
The list that designates which prescriptions are covered and at what copay level.

Generic Drug
A drug which is chemically equivalent to a brand name drug whose patent has expired and which is approved by the Federal Food and Drug Administration (FDA).

Grievance
A written expression of dissatisfaction about any benefits matter other than a decision by a plan provider.

ID Card
The card is provided to you as a member of a health plan. It contains important information such as your member identification number.

Income Related Monthly Adjustment Amount (IRMAA)
Individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income related monthly adjustment amount.

Late Enrollment Penalty
An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount if you have a Medicare drug plan.
There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive “Extra Help” you do not pay a penalty, even if you go without “creditable” prescription drug coverage.

Low Income Subsidy (LIS)
A program to help people with limited income and resources pay Medicare prescription drug program

costs, such as premiums, deductibles, and coinsurance.

Long-Term Disability
A type of insurance through which you will receive a percentage of your income if you are unable to work for an extended period because of a non-work-related illness or injury.

Mail-Order Pharmacy
A service through which members may receive prescription drugs by mail.

Medically Necessary
Services or supplies that are, according to medical standards, appropriate for the diagnosis.

Medicare
The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan and prescription drug coverage through a Medicare Advantage Prescription Drug plan (MA-PD) or a stand-alone Prescription Drug Plan (PDP) that works with Original Medicare.

Member
A person who is enrolled in the health plan.

Member Services
A group of employees whose function is to help members resolve insurance-related problems.

Network
The collection of contracted healthcare providers who provide care at a negotiated rate.

Out-of-Pocket Maximum
The annual amount the member will pay before the health plan pays 100% of the covered expenses. Out-of-pocket amounts do not carry over year to year.
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Over-the-Counter (OTC) Drug
A drug that can be bought without a prescription.

Part D Drugs
Drugs that can be covered under Part D. We may or may not offer all Part D drugs (see your formulary for a specific list of covered drugs). Certain categories of drugs were specially excluded by Congress from being covered as Part D drugs.

PPO (Preferred Provider Organization)
A type of health plan that allows members to use out-of-Network providers but gives financial incentives if members use in-Network providers.

Pre-Certification/Prior Authorization
The prospective determination performed by the Medical Vendor to determine the medical necessity and appropriateness of a proposed treatment, including level of care and treatment setting.

Preventive Care
The combination of services that contribute to good health or allow for early detection of disease.

Choice90RX Retail Pharmacy
A program that allows members to get up to a 90- day supply of covered prescription drugs from a participating retail pharmacy.

Social Security Administration
The Federal agency that determines, among other things, whether you are entitled to and eligible for Medicare benefits.

Specialty Drugs
High-cost drugs that are used to treat complex conditions, such as anemia, cancer, hepatitis C, and multiple sclerosis, and that usually require injection and special handling. Plans can include these drugs in a separate “specialty” drug tier if their cost is above an amount specified by Medicare.

Usual and Customary (UNC) Charges
The standard fee for a specific procedure in a specific regional area.

Contact Information

Plan	Vendor Name	Phone	Website | Email | Policy Information
Benefit Options	ADOA HR Division-Benefits 100 N. 15th Ave., Ste. 301 Phoenix, AZ 85007	602-542-5008 800-304-3687 FAX: 602-542-4744	Info: benefitoptions.az.gov Enroll: benefitoptions.az.gov/retiree Email: benefits@azdoa.gov
Dental Plans	Cigna	800-968-7366	view.ceros.com/cigna/stateofaz/ Group: 2500541
	Delta Dental of Arizona	602-588-3620 866-978-2839	deltadentalaz.com/adoa Group: 77777-0000
Long-Term Disability Plans - LTD	Broadspire Services, Inc. ASRS	877-232-0596	azasrs.gov/content/long-term-disability
	MetLife PSPRS, EORP, CORP & ORP	866-264-5144	Info: metlife.com/stateofarizona/ Claims: mybenefits.metlife.com/stateofarizona
Medicare	Medicare	800-633-4227 TTY: 877-486-2048	Info: medicare.gov Accounts: mymedicare.gov
Medical	Blue Cross Blue Shield of AZ	866-287-1980	2022 Info: azblue.com/stateofaz Members: azblue.com Group: 30855
	UnitedHealthcare	800-896-1067	2022 Info: whyuhc.com/stateofaz Members: myuhc.com Group: 705963
Retirement Systems	Arizona State Retirement System (ASRS) 3300 N. Central Ave Phoenix, AZ 85012	602-240-2000 800-621-3778	azasrs.gov
	● Public Safety Personnel Retirement System (PSPRS) ● Elected Officials Retirement Plan (EORP) ● Corrections Officer Retirement Plan (CORP) 3010 E. Camelback Rd, #200 Phoenix, AZ 85016	602-255-5575 877-925-5575	psprs.com
Vision Plan	Avesis, Inc.	888-759-9772	avesis.com/arizona Policy: 11001-2178
Wellness – Flu Shots	ADOA HR Division-Benefits	602-771-9355	wellness.az.gov/flushot wellness@azdoa.gov